Horizons Health Services & a Primary Care Proposal for New Hanover Regional Medical Center - Jack Barto, CEO

Kenny House, LCAS, CCS
Clinical Director
Coastal Horizons Center
September 26, 2013

Who We Are and What We Do

***Our Mission*: Coastal Horizons Center promotes choices for healthier lives and safer communities by providing a continuum of professional services for prevention, crisis intervention, sexual assault victims, criminal justice alternatives, and treatment of substance use and mental health disorders.**

***A New Purpose*: In the context of our mission, we have added primary care services at our outpatient treatment locations in New Hanover, Pender & Brunswick counties – with the recent help of federal funding. Our goal is to integrate care with Coastal Horizons patients that are in need of a medical home while receiving our behavioral health outpatient treatment services.**

What are we treating in primary care from our MH/SUD population?

- **Hypertension (38%)**
- **Hyperlipidemia - elevated cholesterol (23%)**
- **Diabetes (3%)**
- **Smoking (45%)**
- **Obesity/Overweight (16%)**
- **Providing care such as physical exams, pap smears, ear irrigation, blood pressure monitoring, blood work, Rx assistance, diabetes testing, ECG, treating colds, minor injuries, working with opioid-dependent patients, and handling vague & difficult to resolve complaints/symptoms.**
- **We also provide a team approach – including Wellness services such as health coaching, diabetes education, cholesterol management, weight management, nutrition classes, and tobacco recovery.**

Proposing a Pilot Project: The Evidence To Date

- **From January 2010 thru December 2012, we treated 421 patients with primary care; of those, only 2 patients that we know of needed to utilize the ED!**

(note: completely anecdotal – we did not track)

- **Since May 2013, under our new federal grant, we have treated 155 new patients (thru August 2013); of those, we know that only 5 patients have needed to utilize the ED (3.2%)!**

(note: thru January 2014, closer to 10% - but we always ask & record)

- **Prior to establishing us as their medical home, however, 63 of those patients had utilized the hospital ED in the previous 6 months (40.6%)!**

(note: thru January 2014, closer to 50% - & always asking & recording)

So, we are learning about keeping MH/SUD patients engaged in care & out of the ED! These are those same patients who are uninsured (90%), and who would otherwise be utilizing the ED at a disproportionately high rate!

Proposing a Pilot Project Opportunities & Challenges

The evidence to date is showing that a strategic partnership between NHRMC & CHC could create opportunity for:

- Improved & Preventative Care – for those suffering with SU & MH Disorders who show up disproportionately at the ED;
- **Saving Time, Resources & Money by keeping those patients out of the ED – at a potential 13:1 ratio (40.6% vs. 3.2% - *currently 50% vs 10%, still 5:1*);** and,
- Pioneering the pathway for the future of integrated health care models

Proposing a Pilot Project Opportunities and Challenges

- The federal funding is only going to last 3 more years, and in and of itself, it is not sufficient for us to sustain ourselves
- There are sub-populations NOT supported by the federal funding – eg, the uninsured SUD patient with no MH diagnosis
- Reimbursements are not yet sufficient to offset the total operating costs of our model

Proposing a Pilot Project: The Costs & A 2-part Proposal

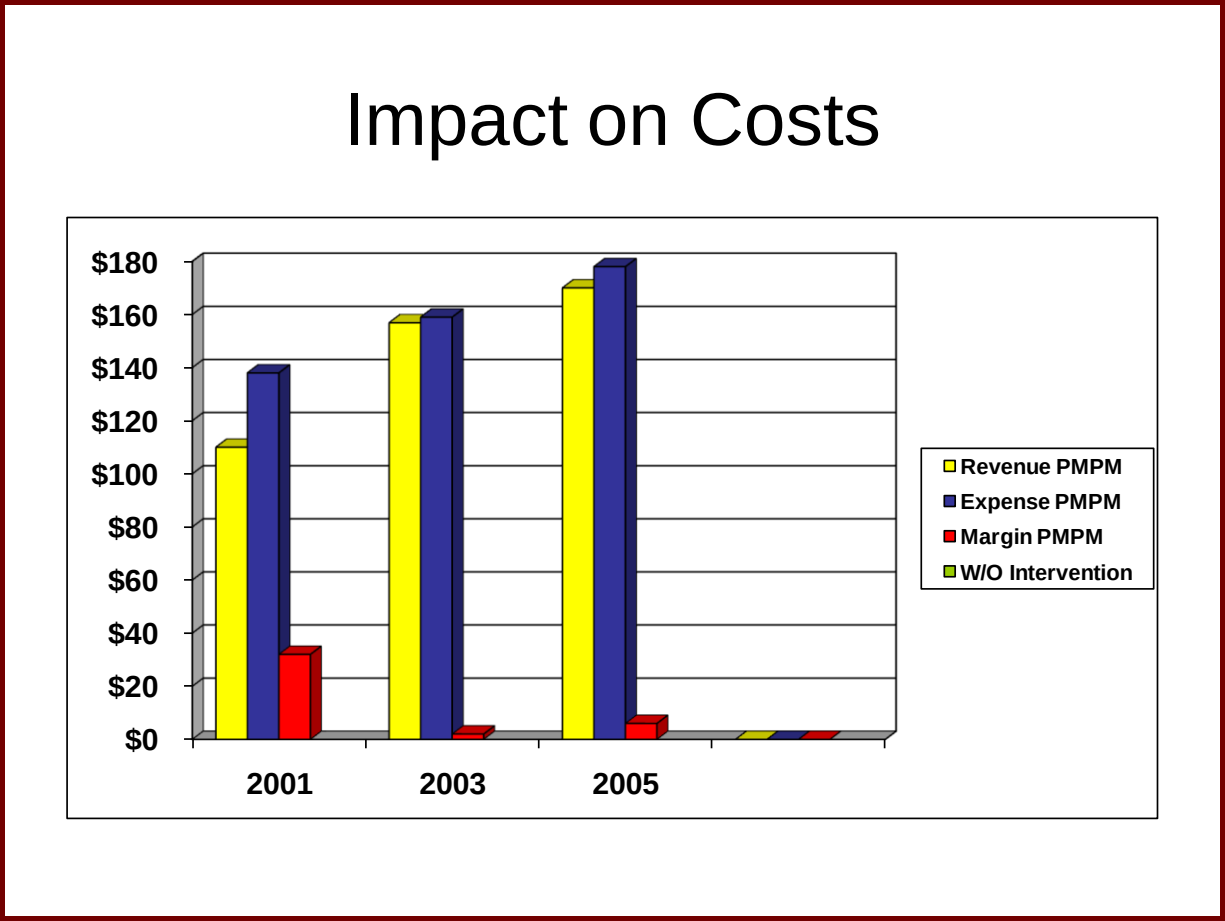
- **Our cost for a new patient is $200, and for an existing patient is $125; our understanding is that this is less than half of the minimum cost when a patient presents at the ED. Our current primary care structure costs us $10,000 per week to run.**
  - **We are proposing a pilot project over a 3-year period – with NHRMC sharing costs, or more accurately, sharing cost savings, by CHC keeping our SUD & MH patients out of the ED**
  - **Additionally, we are interested in developing a process to reduce ED congestion & over-utilization from SUD/MH patients overall**

Update

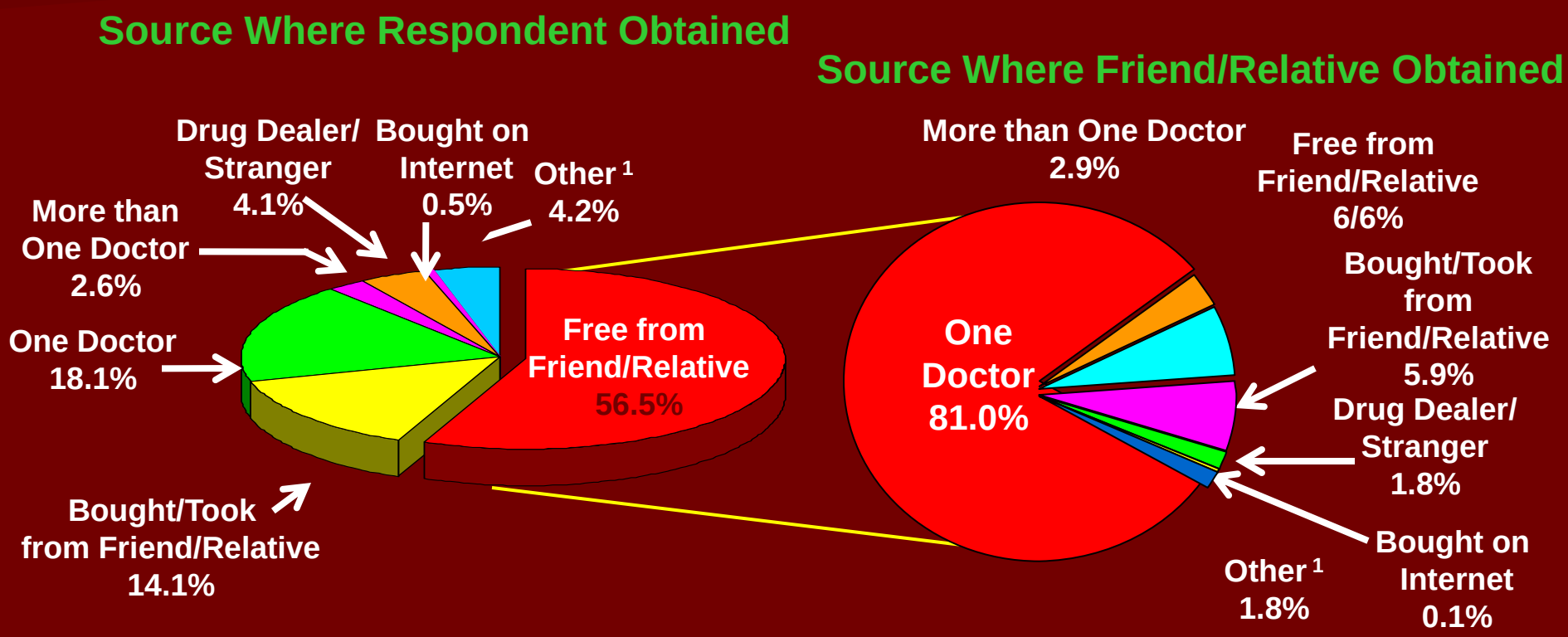
- LEAN process with hospital
- Q&A, sent proposal w/o exact $$ amounts
- Strategic Plan inclusion
- Seeking other funding & expertise:
  - Contracts for co-location at primary care locations (hospital, FQHC, & seeking others)
  - Grants: UWay & Private Foundation
  - TA & Practice Management from local vendor SEAHEC

Background & Context for Care Integration

Return on Investment – PC



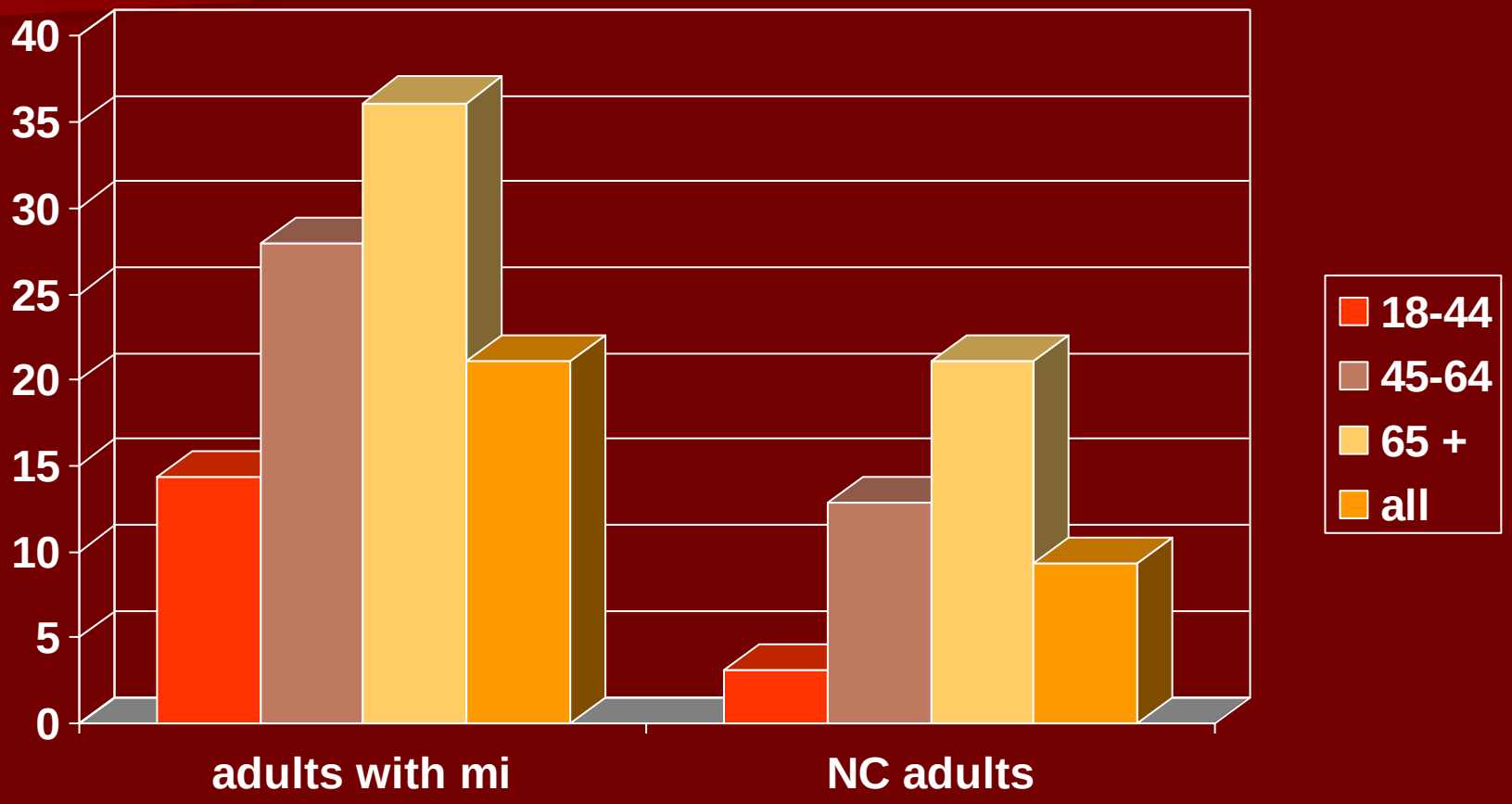
Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2007



Note: Totals may not sum to 100% because of rounding or because suppressed estimates are not shown.

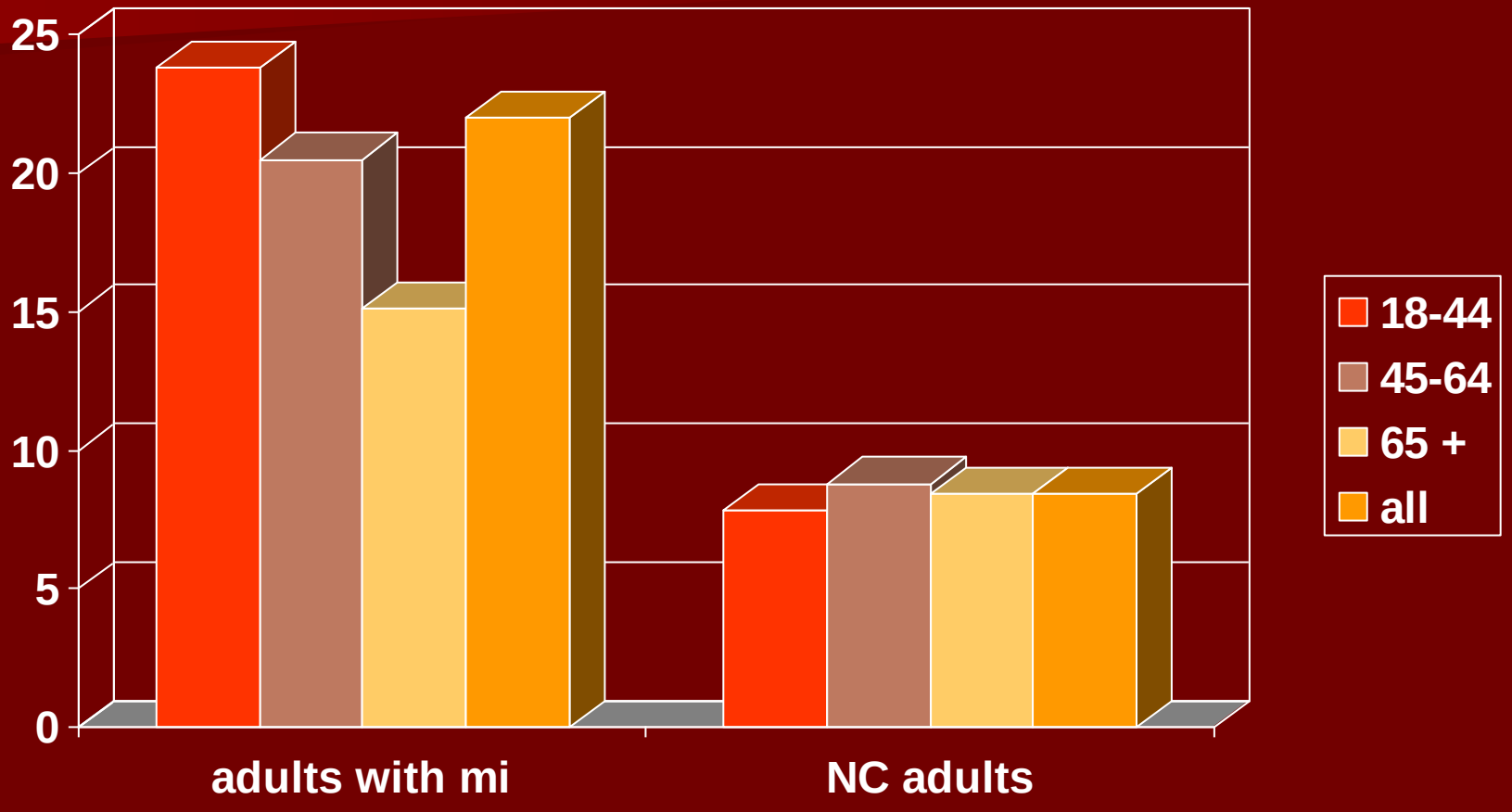
[1] The Other category includes the sources: "Wrote Fake Prescription," "Stole from Doctor's Office/Clinic/Hospital/Pharmacy," and "Some Other Way."

Diabetes



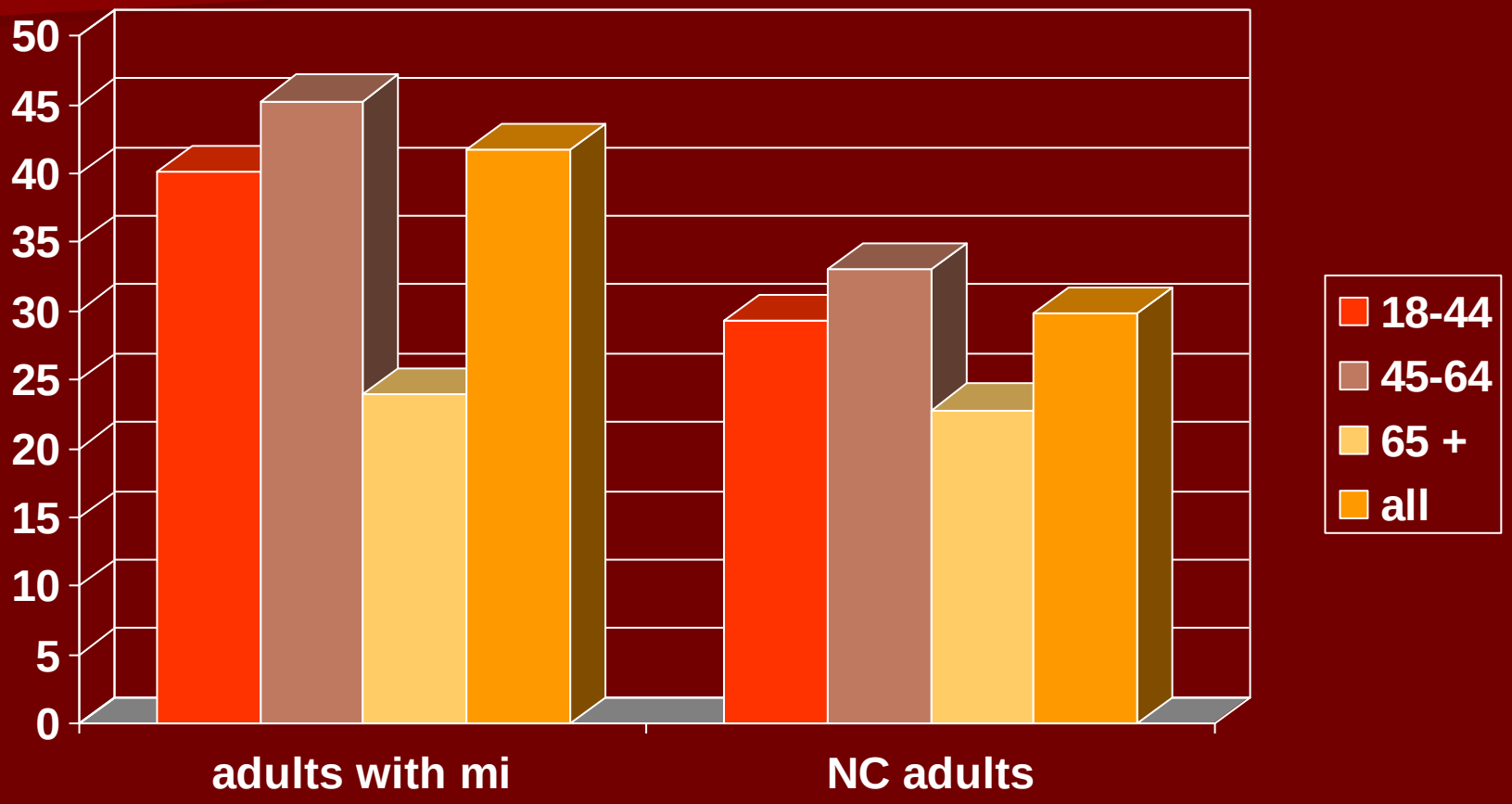
Fernandez M, Boone J, Merrill D,Thompson S, Ebron B. Health Status of People with SMI DMH/DD/SAS Raleigh, NC September 2010

Asthma



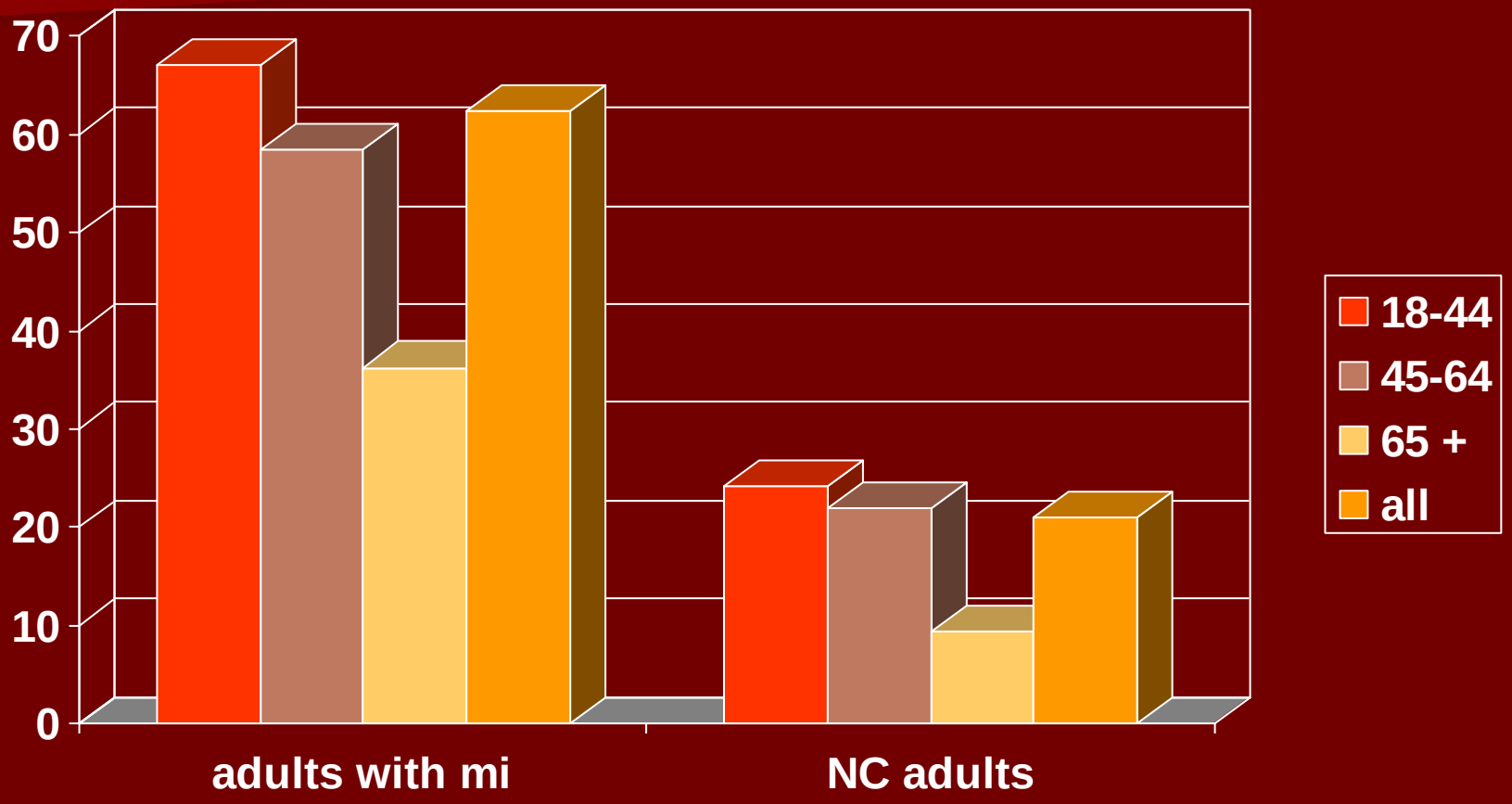
Fernandez M, Boone J, Merrill D,Thompson S, Ebron B. Health Status of People with SMI DMH/DD/SAS Raleigh, NC September 2010

Obesity



Fernandez M, Boone J, Merrill D,Thompson S, Ebron B. Health Status of People with SMI DMH/DD/SAS Raleigh, NC September 2010

Smoking



Fernandez M, Boone J, Merrill D,Thompson S, Ebron B. Health Status of People with SMI DMH/DD/SAS Raleigh, NC September 2010

Impact of Co-morbidity

People with serious mental illnesses die 25 years earlier than the general population

- 87% due to medical illness especially:

  Infectious, pulmonary, cardiovascular diseases, and diabetes.

Parks,J, Radke,A, Mazade,N, and Mauer,B NASMHPD 16th Technical Report : Measurement of Health Status for People with Serious Mental Illness. October 16, 2008.

Substance Use

- Higher rates of injury, pain syndromes (low back pain and headache), hypertension, Hepatitis C, and lung disease
- Subpopulations – Higher rates of pneumonia, CAD, and CHF

Mertens, J. R., Lu ,Y. W., Parthasarathy, S., Moore, C. & Weisner, C. M. (2003). Medical and psychiatric conditions of alcohol and drug treatment patients in an HMO:comparison with matched controls. Archives of Internal Medicine, 163(20), 2511-7.

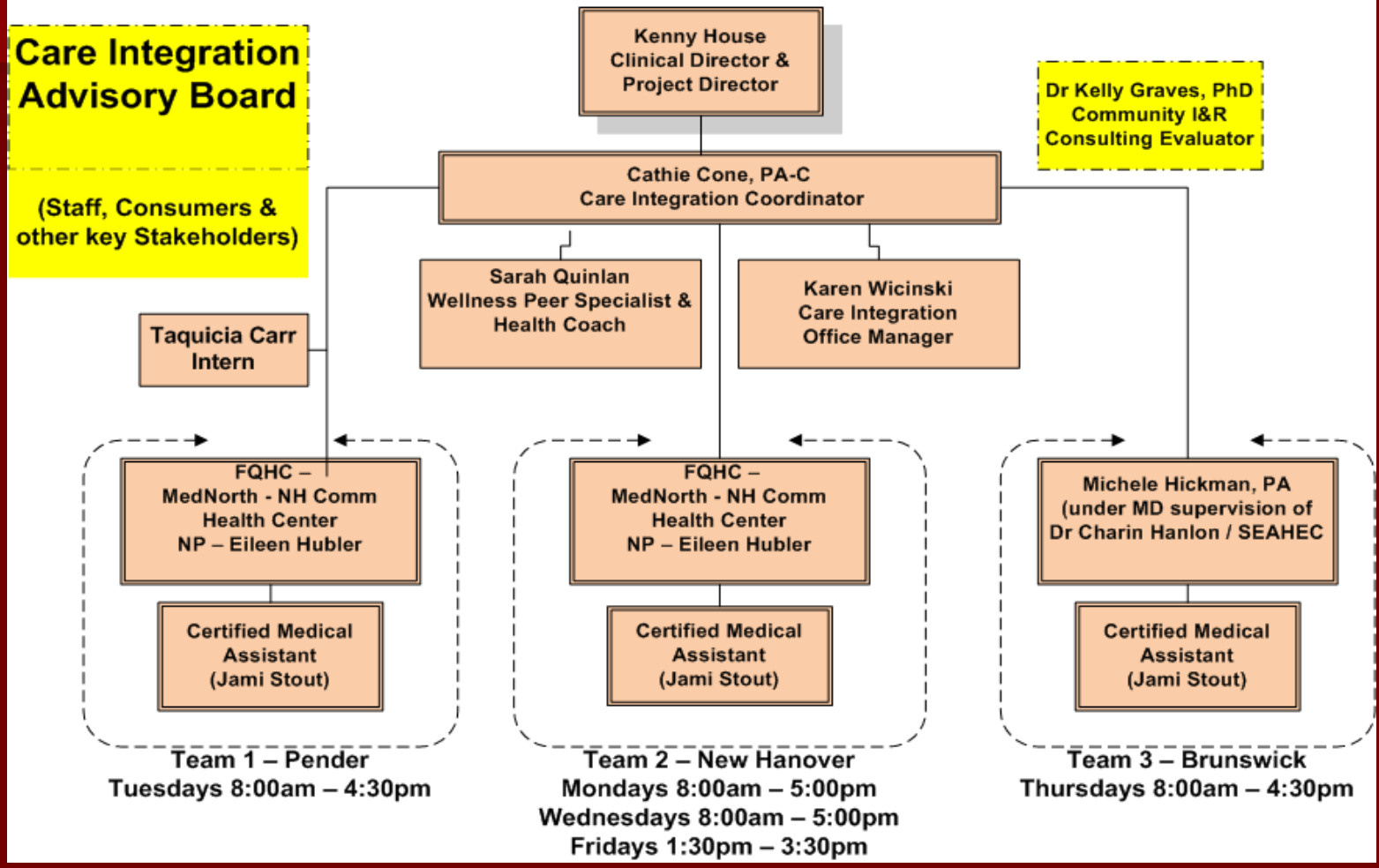
Guiding Principles

- ***Overall health is essential to mental health.***
- ***Recovery includes wellness***
- ***Integrated Healthcare in the Mental Health System for People with Serious Mental Illnesses***

Parks,J, Radke,A, Mazade,N, and Mauer,B NASMHPD 16th Technical Report : Measurement of Health Status for People with Serious Mental Illness. October 16, 2008.

Coastal Horizons
Primary & Behavioral Health
Care Integration Team Structure

(9/9/2013)



Advisory Board

- Anganette Young - MedNorth Community Health Center (FQHC)
- Althea Johnson - MedNorth Community Health Center (FQHC)
- Olivia Herndon - SEAHEC
- Eline Rhoades - Cape Fear HealthNet
- Patients/ Consumers (5-10)
- Matthew Oelslager - MCO – CoastalCare
- Karen Pleva – New Hanover Regional Medical Center (NHRMC)
- Dr Doug Waldrep – NHRMC & CHC Board member
- Keith Montgomery – New Hanover County Health Department
- Elissa Hanson – Community Care of the Lower Cape Fear
- Dr Virginia Adams – Retired UNCW Dean of Nursing

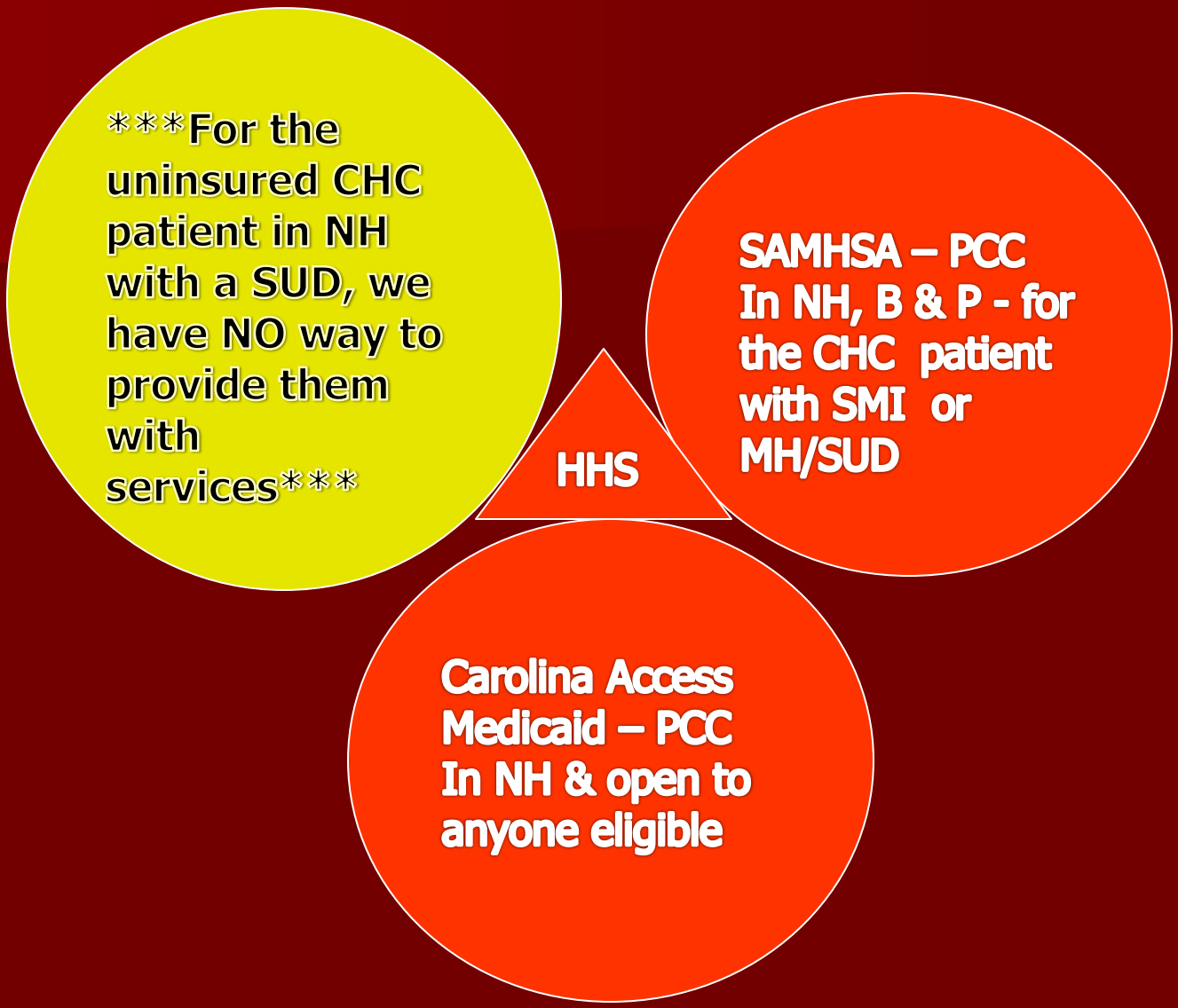
& Coastal Horizons Staff

Key Funding Sources

- SAMHSA PBHCI (Cohort V Grantee)
- Medicaid & other 3rd Party (BCBS, etc)
- Carolina Access Medicaid
- Patient Co-pays

Care Integration

- Primary Care for those who are Carolina Access Medicaid, or who have other 3rd party insurance
- Primary Care for those receiving treatment at Coastal Horizons with SMI or Co-occurring SUD/MH disorders (based in 3 counties – New Hanover, Pender & Brunswick)
- **Key Gap: those with SUDs only & Uninsured**


For the uninsured CHC patient in NH with a SUD, we have NO way to provide them with services
HHS
SAMHSA – PCC
In NH, B & P - for the CHC patient with SMI or MH/SUD
Carolina Access
Medicaid – PCC
In NH & open to anyone eligible

SAMHSA Grant - Health Disparities & Project Goals

- **HHS – PBHCIT proposes to deliver a system of integrated and coordinated care among adults with serous mental illness (SMI) in one urban and two rural clinics in three counties in the state. Coastal Horizons PBHCIT plans to serve at least 200 clients in Year 1, 375 clients in Year 2, 475 clients in Year 3, and 600 clients in Year 4. Our concern for health disparities is to ensure that those who have often been overlooked and underserved get the healthcare services they need for successful outcomes.**

- Project Goals (over a 4-year period)

1 -To provide integrated care to adults with SMI and co-occurring disorders who are served in the selected community mental health centers.

2 -To provide health promotion activities that will modify lifestyle and behavior patterns that are associated with the risk factors for physical illness and chronic conditions that are prevalent for people with SMI, initially focusing on tobacco cessation, nutrition, physical activity, and stress management.

3 - To establish a continuous quality improvement program for the project that will allow for the evaluation of integrated care and chronic disease management on individual level outcomes, perception of care, quality of care, and other outcomes that will be collected by the project.

4 - To sustain the project

5 - To advance the use of health information technology (year 2)

Advisory Board

- Anganette Young - MedNorth / New Hanover Community Health Center
- Althea Johnson - MedNorth / New Hanover Community Health Center
- Olivia Herndon - SEAHEC
- Eline Rhoades - Cape Fear HealthNet
- Linda Ellis
- Matthew Oelslager - MCO – CoastalCare
- Karen Pleva – New Hanover Regional Medical Center
- Christina Smith
- Jay Rochelle

From Coastal Horizons Staff:

- Margaret Weller-Stargell
- Pamela Morrison
- Kate Gomes
- Karen Wicinski
- Jim Ayers
- Liz Uzcategui
- Kenny House

Dr John Harris, MD
Ryan Estes
Cathie Cone
Sarah Quinlan
Jessica Rasino
Deeanna Hale-Holland

PCC Success Stories

- "If you weren't here I would've ended up in the emergency room"
- "Doing a great job getting clients into prescription assistance programs"
- "I appreciate you guys, you're very pleasant and easy to talk to"

In the PCC, we have the ability to "show & tell" the stories of how primary & behavioral care patient problems, & later improvements, move along parallel lines…

PCC Accomplishments
(thru December 2012)

- **421 patients seen**
- Hypertension = 37%
- Hyperlipidemia (elevated cholesterol) = 11%
- Diabetes = 6%
- Smoking = 42%
- Obesity/Overweight = 20%
- Providing annual physical exams on OTP patients
- **182** Flu vaccinations given
- Collaboration with Cape Fear HealthNet
- Collaboration with NHRMC for labs, testing, admissions
- Approval by DMA as Carolina Access Medicaid Provider

"We did what we knew, and when we knew better, we did better."

Maya Angelou